

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 1/01/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2010
NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS An annual recertification survey and complaint investigation #'s 26771, 26875, and 26976, were completed on November 15-17, 2010, at Maryville Healthcare and Rehabilitation. No deficiencies were cited related to complaint investigation #'s 26771 and 26875, under 42 CFR PART 482, Requirements for Long Term Care. Deficiencies were cited related to complaint investigation #26976.	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to ensure an allegation of abuse was reported timely for one resident (#10) of thirty-one residents reviewed. The findings included: Resident #10 was admitted to the facility on January 29, 2009, with diagnoses including Failure To Thrive, Psychosis, and Depressive Disorder. Medical record review of the Minimum Data Set dated August 23, 2010, revealed the resident had short/long term memory problems and moderately impaired cognitive skills for daily	F 224	F-224 This facility has established implemented policies and procedures that prohibit and prevent mistreatment, neglect and abuse of residents and misappropriation of resident property. C.N.A. #5 was terminated as of October 18, 2010. C.N.A #6 has received additional training on what immediately reporting suspected/witnessed abuse means on 11/22/10 as well as a final written warning for failure to follow facility policy. LPN #2 and LPN #3 have been in-services on immediately contacting ED, DNS according to our policy as of 11/30/10. Please note LPN #3 called DNS at 7:10 PM as required by policy. Event reports, morning meeting minutes and 24 hr reports for the last 45 days have been reviewed by DNS, ADNS and no suspected abuse allegations were identified. Review was completed on 12/1/10. Additional in-service training will be conducted by SDC on reporting allegations of abuse immediately on Dec. 6, 7, 20 & 21, 2010 for all staff. RN Nurse Managers will receive additional training on how and when to initiate investigation(s) on events or allegations that are considered abuse that require being reported immediately to the ED / DNS or Designee on Dec. 2, Dec. 3, Dec. 6, & Dec. 7, 2010. Orientation does and will continue to include training on facility policies of abuse and how to report abuse as well as an annual in-services for all staff will continue to be conducted by SDC or Designee on reporting abuse timely. Resident events, incidents, and/or allegations of abuse will be reviewed each week day during the morning	12/22/10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Keith Mandrell

Robert Trice

12/1/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 11/19/2010

FORM APPROVED

OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2010
NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 224	<p>Continued From page 1 decision making.</p> <p>Review of a facility investigation dated October 18, 2010, revealed "...In the shower room...2:00 p.m...10/11/10 during resident W/P (whirlpool). Resident became combative and CNA (certified nursing assistant) attempted to protect...taking (resident's) left arm to (resident's) shoulder...accidentally hit resident in the face...(no) injuries (no) indication of redness or other indicators...Summary Report of Findings: Employee used poor judgement in restraining (resident's) hands and admitted to striking (resident) on top of the head. Resident unable to communicate event. Event was witnessed by CNA...Employee is terminated..."</p> <p>Review of a facility investigation and statement obtained from CNA #5 (accused) revealed "I (CNA #5) unintentionally hit a resident on the cheek cause that resident was going to smack me and I was going to the resident shoulder to tell (resident) to stop but instead I tapped (resident) on the cheek and how fast my hand was going it looked and sounded like I slapped (resident)...across the face..."</p> <p>Review of a facility investigation and a statement obtained from CNA #6 (witness) revealed "On Mon (Monday) Oct 11, around 4:00 I took (resident) in the whirlpool room to give (resident) shower, (CNA #5) went in with me to hold (resident's) hand so (resident) wouldn't hit. When I got the water warm and sprayed (resident) down (resident) was yelling...(CNA #5) was holding (resident's) hand (and)...was still cursing then...was calling us...(and) (CNA #5) slapped (resident) in the face, I didn't say anything because I really didn't know what to say..."</p>	F 224	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>meeting which is attended by ED, DNS, ADNS, SDC, SSD, Admin RNs, RD, CM and RM to ensure policy has been followed which includes but not limited to "reported immediately".</p> <p>The Facility Performance Improvement Committee, ED, DNS, ADNS, SDC, Admin RNs, RD, SSD, AD, MDS Coord. Pharm. Consultant, Medical Dir. Assist. Medical Director) will review all abuse allegations / investigations during its regularly schedule meetings for timeliness and completeness as well as recommend any additional training needs, as indicated.</p>		

PRINTED: 11/19/2010

FORM APPROVED

OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2010
NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 224	<p>Continued From page 2</p> <p>(resident) was quiet for a min (minute) but went back to cursing so (CNA #5) hit (resident) again but not as hard...kept cursing so (CNA #5) twisted (resident's) ear...when I was washing (resident's) legs (and) feet...was fine but when I started washing between (resident's) toes (residnet) lifted...legs like...was going to kick me (and) (CNA #5) put (CNA's) foot on (resident's) leg...finished with (resident) (and) put (resident) at...spot at the nurses station. There was a lot going on and everyone was around the nurses station so I waited until I could talk to (LPN #2) about it...it was so late in the day (and) was very very busy, but before trays came out at 5:30 (LPN #2) had been told..."</p> <p>Review of a facility investigation and a statement obtained from LPN #2 revealed "On the evening of 10/11/10 a CNA (#6) came to me after supper and said...needed to tell me something...proceeded to tell me that when (CNA #6) and a fellow CNA (#5) were giving (resident #10)...shower, (CNA #5) had slapped (resident #10) twice across the face...Everyone was getting ready to leave, it was the end of shift. I asked (CNA #5) in private about the alleged incident. (CNA #5) stated "I didn't slap...I just tapped...I didn't do anything to...foot. (LPN #3) came in and I explained to...what I had been told...(LPN #3) talked to (CNA #5) and instructed...to see the DON first thing in the morning..."</p> <p>Review of a facility investigation and a statement dated October 12, 2010, obtained from LPN #3 revealed "I came to the floor...for the 7p-7a shift. After getting the report the day shift nurse (LPN #2) stated...has a problem and really don't know what to say or do...a CNA (#6) reported that another CNA (#5) had slapped a...resident in the</p>	F 224	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2010
NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 224	Continued From page 3 face during...bath...I met (CNA #6) in the common area (at) 1845 (6:45 p.m.) going to clock out. (CNA #5) was still on the floor till 1900 (7:00 p.m.). I told the nurse...(CNA #5) had to be suspended until an investigation took place. The nurse paged the CNA, who was still here, and I spoke with...and told...needed to come in the AM and speak to adm. (administrator)..." Review of facility policy Responding to and Investigating an Abuse Allegation revealed "...Alleged Physical Abuse...Diffuse the situation, and remove the aggressor from all resident contact...Contact the Executive Director or Director of Nursing immediately..." Interview on November 16, 2010, at 9:30 a.m., in the ICF (intermediate care facility) office with LPN #2 confirmed the allegation of abuse was not reported immediately. Interview on November 16, 2010, at 9:45 a.m., in the ICF office with CNA #6 confirmed the incident was not reported immediately and CNA #5 continued to assist with resident #10. Interview on November 16, 2010, at 10:00 a.m., in the conference room with the Director of Nursing (DON) confirmed the allegation of abuse was not reported immediately.	F 224	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.		
F 241 SS=D	C/O #26978 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	F-241 It is the practice of this facility to promote care for our resident's in a manner that maintains and enhances each resident's dignity. Resident #9 has been moved to another room according to her wishes on 11/19/2010. The resident currently in her room on the 500 hall does use the bathroom independently, and on 11/19/2010 was offered an alternate room by SSD but refuses to do so. She states		12/22/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CENTERS FOR MEDICARE & MEDICAID SERVICES

 PRINTED: 11/19/2010
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2010
NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 241	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure privacy for toileting needs between female and male residents for two residents (#9, #31) of thirty-one residents reviewed.</p> <p>The findings included:</p> <p>Resident #9 was admitted to the facility on January 5, 2010, with diagnoses including Diabetes Mellitus, Chronic Renal Failure, and Hearing Loss. Medical record review of the Minimum Data Set (MDS) dated September 2, 2010, revealed the resident had short and long term memory deficits and moderately impaired cognitive skills for daily decision making. Continued medical record review revealed the resident transferred, dressed, and ambulated independently, was continent of bowel, and usually continent of bladder.</p> <p>Medical record review of a nurse's note dated November 11, 2010, revealed the resident wore incontinent pads for occasional incontinence and ambulated with a rolling walker.</p> <p>Observation during the initial tour on November 15, 2010, at 10:30 a.m., on the 500 hall revealed two female residents and two male residents shared a common bathroom.</p> <p>Interview on November 15, 2010, at 10:50 a.m., with Certified Nurse Assistant (CNA) #7 on the 500 hallway confirmed the two female residents shared a bathroom with the two male residents,</p>	F 241	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>she currently locks the bathroom door when in use to maintain her privacy. The SSD will visit her once a week to monitor for any dignity or privacy issues and will address accordingly. Currently by locking the door while in use has allowed the roommate of resident # 9 and resident #31 to use the bathroom in a manner that promotes mutual dignity and privacy.</p> <p>SSD reviewed all room assignments where residents in a semi-private room shared a common bathroom on 11/19/2010 and through record review and interview and did not identify any issues or concerns related to privacy in bathroom use for toileting.</p> <p>Semi private rooms which share a common bathroom have been identified on each hallway as historically being either male or female to ensure that rooms with shared bathrooms are maintained as same sex when admissions or room changes occur. The Admissions coordinator or designee maintains a copy of the identified rooms discussed as suitemates and consults with IDT (ED, DNS, ADNS, SDC, SSD, and Admin. RNs, RD, AD, CM, RM) at our morning standup meeting for room placement.</p> <p>SSD and/or designee will monitor and report to our facility Performance Improvement committee at its regularly scheduled meetings any resident concerns that were related to dignity, privacy or respect of their individuality and the effectiveness of the appropriate interventions that were implemented for any additional recommendations or changes in procedures, if indicated.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2010
NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 241	Continued From page 5 both female residents toileted themselves, and only one of the male residents was independent with toileting. Interview with resident #9 on November 16, 2010, at 8:30 a.m., in the resident's room confirmed a preference not to share the bathroom with male residents. Continued interview confirmed the male resident had opened the door to the bathroom at times when occupied by the female. Interview on November 16, 2010, at 10:00 a.m., with CNA #8 on the 500 hallway confirmed one male resident was known to toilet independently at times. Interview with the Social Worker on November 17, 2010, at 8:15 a.m., at the 500 hall nurses station, confirmed the social Worker had no knowledge the female and male residents were actively sharing a common bathroom and would notify families for appropriate room changes.	F 241	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280	<p>F - 280</p> <p>It is the practice of this facility to periodically to review, revise and update the comprehensive care plan after each assessment.</p> <p>Resident # 7 fall risk has been re-assessed by ADNS and care plan updated with current interventions and implemented by IDT (ED,DNS,ADNS,SDC SSD, Admin. RNs, AD, RD CM, MDS RN and RM) on 11/16/10.</p> <p>RN managers/supervisors and MDS Coordinators will review the care plans of current residents with a fall in the last 90 days and validate the identified interventions are in place or implement care planned interventions or re-assess resident fall risk and revise care plan and implement the updated interventions with input from the</p>		12/22/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CENTERS FOR MEDICARE & MEDICAID SERVICES

 PRINTED: 11/19/2010
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2010
NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 280	<p>Continued From page 6</p> <p>for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the care plan for one resident (#7) of thirty-one residents reviewed.</p> <p>The findings included:</p> <p>Resident #7 was admitted to the facility on October 13, 2009, with diagnoses including Dementia of Alzheimer's Type, Osteoporosis, Legal Blindness, and History of Syncope due to Bundle Branch Block. Medical record review of the Minimum Data Set (MDS) dated September 16, 2010, revealed the resident had long and short term memory deficits, moderately impaired cognitive skills for daily decision making, and was independent with ambulation.</p> <p>Medical record review of a nurse's note dated August 17, 2010, 12:00 p.m., revealed the resident had a witnessed fall in the resident's room described as "...feet slid out from under...falling on floor and hit...head (back of head) on the floor, small laceration noted with large raised area approximately 2-3 centimeters in diameter..."</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>_____</p> <p>IDT (ED,DNS, ADNS, SDC, SSD, Admin. RNs, AD, RD, CM, MDS RN and RM)</p> <p>Resident falls and revised care planned interventions will be reviewed in the week day Morning Meeting by ED, DNS, ADNS, SDC, SSD, and Admin. RNs, RD, CM, and RM. Nurse managers will monitor the implementation of fall interventions on their routine rounds and report during the weekday Morning Meeting. The Nurse Managers will report on the intervention compliance and effectiveness at the facility's weekly Standard of Care meeting. The SDC will conduct in-services on the facilities fall prevention/intervention program to all nursing staff on Dec. 13, Dec 14, Dec. 20, & Dec. 21, 2010.</p> <p>The ADNS will report on the facility's Fall Prevention/Intervention Program to the Facility Performance Improvement Committee at its regularly scheduled meetings to include but not limited to trends, intervention implementation and effectiveness fro review and recommendations as indicated.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2010
NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page 7 Medical record review of the care plan for falls risk dated October 22, 2009, and revised on August 17, 2010, after the resident's fall revealed "...Attempt to get non-skid strips by bed...d/c (discontinue) can't get due to regs (regulations) per maint (maintenance)..." Medical record review of the care plan dated September 23, 2010, revealed the resident is at risk for falls related to psychotropic medication, history of falls, fractured pelvis and dementia. Continued medical record review revealed the intervention dated August 17, 2010, was "...obtain non-skid material for floor by bed..." Interview with the Assistant Director of Nurses in the resident's room, on November 16, 2010, at 1:15 p.m., confirmed the falls intervention for non-skid material on the floor by the bed had never been implemented as indicated on the current care plan.	F 280	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to ensure fingernails were trimmed and clean for two residents (#7, #17) of thirty-one residents reviewed.	F 312	F-312 It is the practice of this facility for resident who are unable to carry out activities of daily living to receive the necessary services to maintain good nutrition, grooming and personal oral hygiene. The nails of resident 7# and 17# were cleaned and trimmed as of 11/18/2010 and validated by the RN supervisor. All residents nails have been checked to determine if cleaning and or trimming were needed by RN supervisor staff on 11/18/2010. Residents whose nails needed trimming and/or cleaning were completed on 11/18/10. Educational in servicing will be conducted by SDC and or for nursing staff on personal hygiene to include nail care (cleaning and trimming) and the monitoring system the nurse managers will use to ensure compliance as well as the consequences for not performing such duties. This training will occur on Dec.13, Dec. 14, Dec. 20, & Dec. 21, 2010.		12/22/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2010
NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	<p>Continued From page 8</p> <p>The findings included:</p> <p>Resident #7 was admitted to the facility on October 13, 2009, with diagnoses including Dementia of Alzheimer's Type, Anxiety Disorder, Degenerative Joint Disease, and Legal Blindness. Medial record review of the Minimum Data Set (MDS) dated September 16, 2010, revealed the resident had long and short term memory deficits, moderately impaired cognitive skills for daily decision making, and required extensive assistance of one person for personal hygiene maintenance.</p> <p>Medial record review of the care plan dated September 23, 2010, revealed "...Routine Care Needs...2 (two) X (times) W (week)...Fingernails and toenails cleaned and checked..."</p> <p>Observation of the resident's fingernails and interview with Licensed Practical Nurse #4 in the resident's room on November 16, 2010, at 1:00 p.m., confirmed the resident's fingernails were long, had an unidentified brown substance underneath the nails, and needed to be trimmed and cleaned.</p> <p>Resident #17 was readmitted to the facility on April 20, 2009, with diagnoses of Diabetes Mellitus, Cardiac Dysrhythmias, and Dementia. Medical record review of the MDS dated August 15, 2010, revealed the resident had short and long term memory deficits, moderately impaired cognitive skills for daily decision making, and was totally dependent on staff for maintaining personal hygiene.</p> <p>Medial record review of the treatment record for</p>	F 312	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Administrative Nurses: SDC, ADNS, Nursing Supervisors will monitor resident nail care on daily by walking rounds Monday – Friday to ensure compliance with the nail care schedule. Results both of residents nail care condition and staff compliance will be reported in the daily weekday morning meeting.</p> <p>The DNS will report on staff compliance with resident personal hygiene to include nail care at the Facility's Performance Improvement Committee meeting monthly X 3 months, then quarterly thereafter for review and recommendations as indicated.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2010
NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 9 November 2010, revealed "...Diabetic Care: Check nails weekly, trim as needed..." Continued medical record review of the treatment record revealed the nurse had checked the resident's nails on November 14, 2010. Observation of the resident's fingernails on November 15, 2010, at 11:00 a.m., revealed the nails were long with an unidentified brown substance underneath. Observation on November 16, 2010, at 10:10 a.m., and 1:15 p.m., of the resident's fingernails revealed the nails remained untrimmed and dirty underneath. Interview with the Assistant Director of Nursing on November 16, 2010, at 1:15 p.m., in the resident's room confirmed the resident's fingernails were long, dirty, and needed to be trimmed and cleaned. Review of the facility's procedure rationale for providing nail care, Nails, Care of (Finger and Toe), revealed "...Nail care provides cleanliness, prevents spread of infection and prevents skin problems..." Interview with the Staff Development Coordinator (SDC), on November 17, 2010, at 8:30 a.m., in the SDC office confirmed the facility does not have a policy for keeping finger nails clean but it is the facility's expectation the resident's finger nails will be trimmed and cleaned as needed.	F 312	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323	F- 323 It is the practice of this facility to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. Resident #12 was re-assessed on 11/16/2010 by ADNS and no longer requires the anti-tip bars and the care plan	12/22/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2010
NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	<p>Continued From page 10 prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure safety devices were in place for three residents (#12, #8, #15) of thirty-one residents reviewed.</p> <p>The findings included:</p> <p>Resident #12 was admitted to the facility on January 22, 2009, with diagnoses including Hypertension, Dementia with Behavior, and C1-C4 (cervicle) Fracture.</p> <p>Medical record review of the Resident Progress Notes dated January 28, 2010, revealed "...1/27 (at) 1050...flipped ...w/c (wheelchair) backwards (and) hit head...had legs (up) on bed (and) pushed backwards causing w/c to flip back...anti tip bars placed to w/c...no other injuries..."</p> <p>Medical record review of the current care plan dated October 7, 2010, revealed "...Anti-Tip Bars to W/C..."</p> <p>Observation on November 15, 2010, at 11:00 a.m., revealed the resident seated in a wheelchair in the resident's room with no anti-tip bars on the wheelchair.</p> <p>Observation on November 16, 2010, at 2:00 p.m., revealed the resident seated in a wheelchair in the resident's room with no anti-tip bars on the wheelchair.</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>was updated on 11/16/10 to reflect that change.</p> <p>Resident #8 the pressure sensitive alarms are in place and being used this was validated by observation by SDC on 11/24/2010. Resident #15 alarm is in place and is working and was validated by observation 11/24/2010 by SDC.</p> <p>Nurse managers (DNS, ADNS, SDC, MDS Coordinators, Case Manager, RN supervisors, evening supervisors will through resident observation and care plan review audit all residents with fall intervention safety devices by 12/10/2010. A list of these safety alarm devices by resident will be maintained at each nurse's station. this will include a safety alarm device log and the nursing staff will note on the log each shift the device is in place and working properly. In services will be conducted for all direct care staff that are responsible for applying and monitoring bed and chair alarms and other related safety alarm devices to include operation/use per the manufactures' specifications and documentation requirements by our SDC/ Plant Operations Director/ or designee The nurse managers will audit safety alarm device logs and spot check at least 20% of residents on unit who have a safety alarm device to ensure in place and working at least 3 days a week for 4 weeks and then weekly.</p> <p>Nurse Managers will report compliance at the weekday Morning Meeting and will also be responsible to update the list and log daily as changes occur i.e. alarms added or removed. During the weekly Standards of Care meeting the safety alarm device list and log will be reviewed for accuracy and updated as required. The nurse managers will report on the audits conducted on assigned units.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CENTERS FOR MEDICARE & MEDICAID SERVICES

 PRINTED: 11/19/2010
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2010
NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 11</p> <p>Interview on November 16, 2010, at 2:00 p.m., in the resident's room with LPN #5 confirmed no anti-tip bars were on the wheelchair.</p> <p>Resident #8 was admitted to the facility on April 29, 2010, with diagnoses of Severe Dementia, Hypertension, Osteoarthritis, and Depression. Medical record review of the Minimum Data Set (MDS) dated September 23, 2010, revealed the resident had short and long term memory deficits, moderate cognitive impairment for daily decision making, independent with ambulation, and a falls history within the past 31-180 days.</p> <p>Medical record review of a nurse's note dated November 7, 2010, revealed the resident had a fall resulting in a right hip fracture. Medical record review of the resident's interim care plan dated November 11, 2010, revealed resident "At risk for falls r/t (related to) recent falls..." with the current intervention for "pressure sensitive alarm in bed, w/c (wheelchair)..."</p> <p>Observation and interview with Certified Nurse Assistant #7 on November 15, 2010, at 2:20 p.m., in the resident's room confirmed the resident's bed alarm was not in place. Continued observation revealed CNA #7 took the alarm box from the drawer of the nightstand, connected the sensor wire to the alarm box to activate the alarm, and placed the alarm box at the head of the resident's bed.</p> <p>Resident #15 was admitted to the facility on December 28, 2009, and readmitted on October 22, 2010, with diagnoses including Malignant Neoplasm of Prostate, Acute Renal Failure, Acute</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The DNS will report on the audit findings and staff compliance to the Facility's Performance Improvement Committee meeting monthly for review and recommendations as indicated.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2010
NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page 12 Encephalon, Dementia with Behavior Disturbances, Psychosis, Senile Dementia, and Chronic Obstructive Pulmonary Disease. Medical record review of the Minimum Data Set dated August 24, 2010, revealed the resident had short and long term memory impairment, severely impaired decision making skills, totally dependent for transfers, locomotion, dressing, eating, toilet use, personal hygiene and bathing. Further medcial record review revealed the resident had experienced a fall in the past thirty days. Medical record review of a nursing note dated January 3, 2010, at 12:45 p.m., revealed "...Pt (patient) in recliner in hallway-became restless and leaned forward-recliner tipped forward and pt went forward...denies pain. ROM (range of motion) to all extremities WNL (within normal limits)...alarm not sounding..." Medical record review of a nursing note dated February 27, 2010, at 4:50 p.m., revealed "...Pt sitting in hallway in recliner...alarm for safety...pt slide from recliner to floor slowly. (Pt) sat on floor. Denies pain. ROM WNL. Moves extremities without difficulty...Alarm in place-but did not sound. Batteries replaced..." Interview, with the Director of Nursing (DON) on November 17, 2010, at 12:45 p.m., in the DON's office, confirmed the facility failed to ensure the safety device was operational.	F 323	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441	F441 The facility has an established Infection Control Program and provides as safe, sanitary, comfortable environment. Resident #6 was discharged to Blount Memorial Hospital on 11/18/10.		12/22/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2010
---	---	--	---

NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 13</p> <p>to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policies, and interview, the facility failed to maintain infection control measures to</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>ADNS reviewed all residents in the building and determined that no other resident currently required isolation precautions.</p> <p>An Infection Control in-service was completed for C.N.A. 1# on 11/16/2010 and 11/18/2010. The EMT employer was contacted on 11/18/2010 about the infection precaution violations and the employer instructed the EMTs to follow facility policies for isolation and or ask for assistance from facility staff. When facility has a resident on isolation precautions and transport is required the Nurse managers, or charge nurse will monitor and provide instruction as needed to ensure compliance with facility isolation precaution practices. C.N.A. #4 will complete an in-services on hand washing / isolation procedures and demonstrate return demonstration by 12/1/10. Trash and linen receptacles are available and have been placed in Central Supply ready accessible in the event that isolation precautions are required for a resident.</p> <p>ADNS/SDC/DNS will provide education on Transmission-Based Precautions to all staff who have the potential to have contact with a resident in isolation; this includes direct care nursing staff, housekeeping/laundry staff, maintenance staff, dietician/dietary manager, social services and activity staff. Training will include but not limited to the appropriate procedures for entering a resident room, use of personnel protective equipment, exiting a resident room, and handling and transport of potentially contaminated trash and soiled linen, educating visitors and allied medical personnel to ensure they are able to use the proper techniques that are consistent with facility policy</p> <p>This training will be done on Dec. 6, Dec. 7, Dec. 20, & Dec. 21, 2010.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2010
NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 14</p> <p>help prevent the transmission of an infectious disease process for one resident (#6) on isolation of thirty-one residents reviewed.</p> <p>The findings included:</p> <p>Resident #6 was admitted to the facility on August 17, 2010, and readmitted on November 12, 2010, with diagnoses including Multiple Sclerosis, Left Above Knee Amputation, Manic Depressive Disorder, Diabetes Mellitus, Hypertension, Asthma, End Stage Renal Disease with Dialysis, and required isolation related to a diagnosis of <i>Acinetobacter Baumannii</i> (bacteria) present in the wound (Left Knee Amputation).</p> <p>Medical Record review of the Minimum Data Set dated October 19, 2010, revealed the resident was alert and oriented, non-ambulatory, and required assistance with all activities of daily living.</p> <p>Review of facility policy for Disease Specific Information revealed, "...<i>Acinetobacter baumannii</i> are a species of gram-negative bacteria commonly found in water and soil...on the skin of healthy people, especially healthcare personnel...Found in 240 U.S. Military personnel...since the Iraq war began in 2003...The disease is on the increase in military healthcare facilities...coming from Iraq, Kuwait, and Afghanistan...Mode of Transmission...can be spread to susceptible persons by person-to-person contact, contact with contaminated surfaces, or exposure in the environment...can cause death in very ill patients...Prevention and Control...hand-hygiene and contact-isolation precautions..."</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The facility Infection Control Practitioner or designee will monitor all admissions and current residents to ensure that when isolation precautions are ordered that direct care staff are informed and re-educated as needed prior to or no later than upon the initiating isolation precautions. The Infection Control Practitioner will keep in-services log to ensure the affected staff have been properly trained.</p> <p>The Infection Control Practitioner will provide to the Performance Improvement Committee any Transmission Based Precautions ordered and related surveillance information to evaluate staff education and compliance with isolation precaution policies and facility practices for review and recommendations, as indicated.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2010
NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 15</p> <p>Review of facility policy for Multidrug-Resistant Organisms (MDRO) (ie, MRSA, VRE, Acinetobacter baumannii, MDR Enterococci, & C-Difficile) revealed, "...Transmission-Based Precautions are for residents with documented or suspected infection or colonization with highly transmissible or epidemiologically important pathogens for which additional precautions are needed to prevent transmission...The three types of transmission-based precautions are Contact, Droplet, & Airborne..."</p> <p>Review of facility Policy Transmission-Based Precautions revealed "...Place and maintain an adequate supply of appropriate personal protective equipment near the isolation room (e.g., masks, gowns, gloves, goggles, etc.)...Post the appropriate precaution notice on the room entrance door...Place a container for laundry and containers for waste in or near the isolation room ...Criteria for containment bags for linens/laundry in transmission-based areas may include, but are not limited to...Single bag of sufficient tinsel strength to adequately contain the linen/laundry ...Leak-resistant if the laundry is wet and capable of soaking through a cloth bag...identified with labels, color-coded, or other methods so that healthcare workers handle these items safely...Explain to the resident, family and staff the reason(s) for the isolation precautions."</p> <p>Review of facility policy for Regulated Waste Management revealed, "Regulated medical waste is to be separated from the general waste stream at the point of origin...This is generally in the resident care areas...Appropriate containers are to be used at the point of origin, and to store this type of waste until transport...A single, leak-resistant biohazard bag is adequate for</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2010
NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 16</p> <p>containment of regulated medical wastes, provided the bag is sturdy and the waste can be discarded without contaminating the exterior of the bag. Bags should be securely closed for disposal. The contamination or puncturing of a bag requires placement into a second biohazard bag...Place biohazard bags, even if they contain only a small amount of medical waste, in a proper secondary container...Secondary containers are used to accumulate primary containers until transport to the storage site...These container(s) must be appropriate for the type of waste being discarded..."</p> <p>Observation on November 16, 2010, at 8:00 a.m., in the resident's room revealed a red bio-hazard bag on the floor behind the door. Continued observation revealed the resident was in the bed, awake and alert.</p> <p>Observation on November 16, 2010, at 10:00 a.m., revealed the resident's room door opened and two Emergency Technicians (EMT) exited the room with the resident on a stretcher. Continued observation revealed the resident covered with a sheet/blanket and wearing a mask. Continued observation revealed one of the EMT(s) had no gown, or mask on but was wearing black gloves. Continued observation revealed one EMT was wearing gown, gloves, and a mask, when leaving the room, pushing the resident to the end of the hall, to be transported to the dialysis clinic. Continued observation revealed staff, residents and visitors present in the hall. Continued observation revealed Certified Nursing Assistant (CNA #4) in the room took the linens off the bed, placed them in a red bag and exited the room, without washing the hands, and entered another resident's room.</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2010
NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 17</p> <p>Interview with the CNA on November 16, 2010, at 10:05 a.m., in the hall near the resident's room, confirmed the procedure is to put on gloves, gowns, and mask during care, and after completing tasks, remove the gloves, gowns, and mask, and wash the hands.</p> <p>Observation on November 16, 2010, at 10:58 a.m., revealed CNA #1 exited the resident's room, holding one red biohazard bag in the right hand and two red biohazard bags in the left hand, with the bags brushing the CNA's clothes. CNA #1 walked to the biohazard room, set one bag on the floor while pressing the key pad on the door to open the door. Continued observation revealed CNA #1 placed the bags in the biohazard room.</p> <p>Interview with CNA #1 on November 16, 2010, at 12:53 p.m., in the biohazard room, confirmed the red biohazard bags had been in the resident's room on the floor. Continued interview revealed CNA #1 gloved, tied the bags, and carried them to the biohazard room, allowing the bags to brush against the CNA's clothing; placed the red bags in the biohazard room, but denied setting the bags on the floor outside the biohazard room door. Continued interview with CNA #1 revealed "...was not aware of the special type of isolation (or the diagnosis) for the resident, just that the resident was placed on isolation..."</p> <p>Interview with Housekeeper #1 on November 16, 2010, at 1:15 p.m., in the biohazard room, confirmed after cleaning the room, Housekeeper #1 bagged the mop head in a red biohazard bag, took it to the biohazard room, but denied knowledge of why the resident was on isolation and how to handle the cleaning of the room.</p>	F 441			

PRINTED: 11/19/2010

FORM APPROVED

OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2010	
NAME OF PROVIDER OR SUPPLIER MARYVILLE HEALTHCARE AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 JAMESTOWN WAY MARYVILLE, TN 37803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 18 Interview with the Director of Nursing (DON) on November 17, 2010, at 9:00 a.m., in the DON's office, confirmed the Emergency Technician(s) should not have exited the room with the gown, gloves, and mask on; and there was no reason for the resident to wear the mask. Continued interview confirmed CNA #4 should have donned gloves, gown, and mask before and during care, and removed them after care, washed the hands before leaving the room and after leaving the room. Continued interview with the DON confirmed the facility isolation policy did not include the use of barrels or boxes to keep the red biohazard bags off the resident's floor, to prevent environmental contamination.	F 441		